BODYWORKS
Therapy Specialists

ADULT SLEEP/WAKE QUESTIONNAIRE

Patient Name: Sex: Age:

Date: Occupation: Usual Work Hours:

Marital status: Single Married Divorced Widowed

Please complete the following questionnaire by placing the most appropriate number next to the option

1=Never/Almost Never 2=Sometimes 3= Almost Always.

Difficulty in falling asleep

Difficulty in staying asleep (wake during night)

Restless and disturbed sleep

Wake feeling sleepy following a full night's sleep

Daytime sleepiness

Poor sleep for significant other secondary to my sleep habits

Where do you typically fall asleep: couch chair bed

Typical energy level is best in: morning mid-afternoon evening

Average hours of sleep per night:

Please fill in the best answer regarding the indicated problem or difficulty by using the following scale:

1=Never/Almost Never 2=1-2 times/wk. 3=3-4 times/week 4= Nearly every day

	1	2	3	4
Multiple Injuries				
Teeth Grinding				
Bedwetting				
Daytime Fatigue				
Snoring				
Gasping				
Choking				
Teeth Clenching				
Dry or Sour Mouth in Morning				
Restless Sleep				
Mouth Breathing				
Night Terrors				
Daytime Fatigue				

Past Sleep Evaluation and Treatment

Yes No

I have had a previous sleep disorder evaluation

I have had a previous overnight sleep study

I have had a daytime nap study

I have been prescribed a CPAP or bilevel PAP machine for home use

I have had surgical treatment for a sleep disorder

I have previously been prescribed medication for a sleep disorder

I have previously been treated for a sleep disorder

Habits

Do you smoke? Yes No

Do you drink alcohol? Yes No

If yes : What? dropdown Frequency Amount per Week: dropdown

WELLNESS QUESTIONNAIRE

Circle the number that best describes your experiences, 1 being Extremely Mild and 10 being Extremely Severe….

	1	2	3	4	5	6	7	8	9	10
Sleep Disruptions										
I've Been Told I Snore										
Fatigue										
Irritability										
I would currently rate my sleep issues as a										
Nervousness										
Chronic pain										
Worrying										
Mood Swings										
Joint Pain										
Loss of Memory										
Difficult Concentrating										
Depression										
Headaches										
Weight Gain										
Excessive Sweating										

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BERLIN SLEEP QUESTIONNAIRE

1- Do you snore?
   a. Yes
   b. No
   c. Don't know

If you snore:

2- Your snoring is:
   a. Slightly louder than breathing
   b. As loud as talking
   c. Louder than talking
   d. Very loud-can be heard in adjacent rooms

3- How often do you snore:
   a. Nearly every day
   b. 3-4 times a week
   c. 1-2 times a week
   d. 1-2 times a month
   e. Never or nearly never

4- Has your snoring ever bothered other

People?

   a. Yes
   b. No
   c. Don't know

5- Has anyone noticed that you quit breathing during your sleep?
   a. Nearly every day
   b. 3-4 times a week
   c. 1-2 times a week
   d. I -2 times a month
   e. Never or nearly never

What is your height?

Current weight?

Weight last year?

6- How often do you feel tired or fatigued after your sleep?
   a. Nearly every day
   b. 3-4 times a week
   c. 1-2 times a week
   d. 1-2 times a month
   e. Never or nearly never

7- During your waking time, do you feel tired, fatigued or not up to par?
   a. Nearly every day
   b. 3-4 times a week
   c. I-2 times a week
   d. 1-2 times a month
   e. Never or nearly never

8- Have you ever nodded off or fallen asleep while driving a vehicle?
   a. Yes
   b. No

If yes:

9- How often does this occur?
   a. Nearly every day
   b. 3-4 times a week
   c. I-2 times a week
   d. I-2 times a month
   e. Never or nearly never

If yes:

Have you ever been involved in an accident as a result of nodding off?

   a. Yes-Date of accident
   b. No

10- Do you have high blood pressure?
   a. Yes
   b. No
   c. Don 't know